KINGHAVEN
TREATMENT CENTRE

KINGHAVEN REFERRAL PACKAGE

This referral package must be completed by a drug and alcohol counsellor, a therapist, a mental health worker, a health care professional or a community support worker in collaboration with the client, not by the client on his own.

Before submitting your referral package, please note the following information:

- ☐ Case Manager is assigned to the client and has:
  - ☐ Filled out their contact information on page 1
  - ☐ Obtained signatures on pages 4, 6 and the Pharmacare consent agreement on the last page.
  - ☐ Completed HONOS and GAIN Assessments

- ☐ MSDSI Funding verification provided if applicable (Page 7). Client will be best served by taking this form by hand to his local MSDSI office for completion and then faxing it directly to us. Relying on faxing to the ministry may delay our receipt of the completed form and therefore delay setting up a bed confirmation and intake date.

- ☐ For all other funding, please see Page 2 in the referral package.

- ☐ Current TB test complete and attached (TB test can be submitted separately when available).

- ☐ Review with the client the Checklist of What to Bring and What Not to Bring (Page 14).

- ☐ If the client is on medications, please ask him to bring a written prescription for 1 week to ensure he has adequate supply to last until he sees our house physician. ***Written prescriptions are mandatory for methadone.***

  Note: If the client's Pharmacare registration is not valid or if he has a deductible he will need to self-pay for medications even if he is on MSDSI. If there is any doubt, please ask him to call Pharmacare at 604-683-7151 from Vancouver or toll free at 1-800-663-7100 from the rest of B.C.to confirm his status. ***Kinghaven does not pay for or extend credit for any medications. The client is responsible for ensuring that he has Pharmacare coverage, funds for self-pay or extended health insurance from an insurer approved by Shoppers Drug Mart for direct billing.***

- ☐ Inform client to call 604-864-0039, Ext. 213 daily after 9am to check in. Clients can leave a message and intake will respond as necessary. ***Failure to call may result in the client being removed from the waiting list.*** Our toll free number is 877-864-0039.

- ☐ Kinghaven does not monitor or manage court conditions. Clients must self-monitor to ensure compliance. Kinghaven will not be responsible for reporting breaches.

- ☐ Ensure the client has no court dates or other legal obligations during his time in treatment.

- ☐ Clients with court conditions that require Kinghaven staff to escort them when off the property will not be admitted. Kinghaven does not supervise off-site activities.

Admissions at Kinghaven:

Admissions are by appointment only. Our intake times are Monday to Thursday, 10am to 12pm. We do not schedule intakes for Fridays, weekends or statutory holidays. Exceptions may be made to these schedules for clients arriving from outside the Lower Mainland/Fraser Valley area.

Please fax completed application and any follow-up paperwork to 1-604-864-9420. For additional information please call Doug Edgar, Admissions Coordinator at 1-604-864-0039, Ext 213.

KINGHAVEN
PEARDONVILLE HOUSE
SOCIETY

KINGHAVEN TREATMENT CENTRE

REFERRAL FORM

Date: _____

CLIENT INFORMATION

Last Name: First Name(s): Middle Name:

Address: City: Postal Code:

Home Phone: Cell Phone:

OK to speak to another member of household? ☐ Yes ☐ No OK to leave message? ☐ Yes ☐ No

SIN: PHN:

Date of Birth: Place of Birth: Age:

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Marital Status: ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced

☐ Concurrent Disorder ☐ Methadone Maintenance

REFERRING AGENCY INFORMATION

Referral Agent Name: Referring Agency:

City: Email:

Telephone: Fax:

Please provide a brief explanation of the client's motivation and purpose in seeking treatment at Kinghaven. Include assessment of client's readiness for residential treatment, especially their ability and willingness to participate in group therapy.

How often have you seen this client?

How did this client come into your care?

What do you see are this client's personal strengths/abilities?

What are the client's treatment objectives?

List barriers you believe this client faces in achieving the treatment objectives.

List concerns you have regarding this client's ability to function in a residential treatment setting.

In your opinion, what stage of change is this client currently in?

☐ Pre-contemplative ☐ Contemplative ☐ Preparation ☐ Action

☐ Maintenance ☐ Relapse

Please provide any additional information that may assist in determing your client's suitability for residential treatment at Kinghaven:

Referral Agent's Signature: _____ Date: _____

FINANCIAL INFORMATION

How will the client be paying for your treatment at Kinghaven?

☐ MSDSI (Income Assistance) ☐ ADS ☐ Self Pay ☐ Other _____

Is the client currently receiving: ☐ EI Benefits ☐ Pension ☐ Other Income (if so, specify)

If MSDSI, the Confirmation of Funding form on Page 7 must be completed, stamped and signed by the Ministry.

If Self Pay, we accept Visa, MasterCard, Cash, Certified Cheque or Money Order. Payment is due on admittance. Please call for current rates. Please note that Employment Insurance and Canada Pension Plan do not pay for treatment.

For further information, contact the Admissions Cordinator at 604-864-0039, Ext 213.

TREATMENT INFORMATION

Has the client been a resident at Kinghaven before? ☐ Yes ☐ No When?_____

If yes, did he complete the program? ☐ Yes ☐ No

Has he attended other treatment centres and/or programs? Please list. ☐ Yes ☐ No

Reasons for leaving previous treatment:

What is his number one drug of choice?

Which other substances does he regularly use?

☐ Alcohol	☐ Cocaine	☐ Crystal Meth	☐ Methadone
☐ Cannabis	☐ Heroin	☐ Benzodiazepines	☐ Other:

MEDICAL & MENTAL HEALTH INFORMATION

Is the client mentally stable with no current psychiatric concerns?	☐ YES	☐ NO
Does the client have a history of mental illness?	☐ YES	☐ NO
Is the client actively suicidal?	☐ YES	☐ NO
Has the client been suicidal in the past six months?	☐ YES	☐ NO
Does the client have a history of self-injury?	☐ YES	☐ NO
Has the client been hospitalized in the last 30 days?	☐ YES	☐ NO

If yes, for what reason? _____

Has the client

Ever had a blackout?	☐ YES	☐ NO
Ever had a seizure?	☐ YES	☐ NO
Ever had an overdose?	☐ YES	☐ NO

Client's Height: _____ Weight: _____.

What mental health conditions has the client been treated for by a mental health professional or physician during his lifetime?

☐ Depression	☐ Sleep Disorder	☐ Substance-Related Disorder
☐ Schizophrenia	☐ Other Personality Disorder	☐ Conduct Disorder
☐ Bi-Polar	☐ Psychosis	☐ Dissociative Disorder
☐ Anxiety	☐ Impulse Control	☐ Borderline Personality Disorder

☐ Other _____

If the client has been hospitalized for any of the above conditions in the past year please provide copies of psychiatric consultations. If the client is currently in hospital please also provide a letter from his doctor confirming that he is treatment ready and a suitable candidate for the Kinghaven or Valley House program.

Please provide additional information for mental health conditions such as: date of official diagnosis, treatment, current mental health stability, first and last incidence of symptoms, etc.

_____

Has the client been diagnosed with a brain injury? Yes ☐ No ☐

If yes, please attach medical information to help us determine an appropriate course of treatment.

Is the client taking prescription medication? ☐ Yes ☐ No

List all medications: _____

If yes, a prescription for one week of medications is required upon admission.

Is the client on the methadone or suboxone maintenance program? ☐ Yes ☐ No

Prescribing Doctor: _____ Dosage: _____

If yes, a prescription for 1 week is required upon admission.

If prescribed benzodiazapines, Z-drugs or short acting dexetroamphetamines or methylphenidates, clients must agree to taper down or off while they are here in consultation with the Kinghaven consulting physician. Does your client agree to taper down or off from his current doses while he is attending Kinghaven?

☐ Yes ☐ No

(Refusal to taper down or off these medications may result in the refusal of this application?)

Please have client sign here to confirm his agreement: _____

LEGAL INFORMATION

Current Status: ☐ CSO ☐ Parole ☐ Bail ☐ Probation ☐ N/A

Court Dates: ☐ Yes ☐ No Dates:

Can these court dates be postponed until treatment has been completed? ☐ Yes ☐ No

Is the client currently incarcerated? ☐ Yes ☐ No If "Yes" – Release Date: _____

List the offences he has been convicted of (both past and present):

_____

What support groups is he involved with, and for how long has he been involved?

Is this application for treatment a requirement of his parole package? ☐ Yes ☐ No

Please be aware that clients will not be given permission to be absent from the program for court appearances. Arrangements will need to be made prior to admission for court dates to be completed or rescheduled. A copy of your client's Probation/Bail conditions needs to be submitted prior to entry into the program.

***Please Note**: If this referral is being made from a correctional institution, please attach a copy of the progress notes from any completed program and any completed assessments along with this application.*

P.O.'s Name: _____ Phone: _____

AFTERCARE INFORMATION:

As a requirement for acceptance, clients must have a confirmed aftercare plan including place of residence, transportation and support.

Where will the client be living after completing his treatment program? ***What is the client's housing plan in case of early discharge?

What transportation plans are in place after completing treatment. ***What are the plans in case of early discharge?

What are the client's plans for support following treatment?

MISCELLANEOUS NOTES:

EMPLOYMENT READINESS PROGRAM

Kinghaven has introduced an Employment Readiness Program. Please refer to the Kinghaven website for more information at http://kinghaven.ca/employment-readiness-program/.

INFORMED CONSENT TO TREATMENT

I, _____, agree and consent to participate in addiction and/or mental health treatments services offered and provided by *Kinghaven Peardonville House Society*. I understand that I am consenting and agreeing only to those services that *Kinghaven Peardonville House Society* staff is qualified to perform within (1) the scope of the staff members' certification and training and (2) the scope of the certification and training of staff directly supervising the services received by clients at *Kinghaven Peardonville House Society*.

I acknowledge and agree that during my stay at Kinghaven I will be subject to mandatory, random drug testing, bag searches and room inspections at the discretion of staff.

Client Name:_____

Client Signature:_____

Witness:_____

DECLARATION

I, _____, hereby certify the above statements to be true to the best of my knowledge. By signing this declaration, I give consent to have information about my referral, admission and treatment shared with my referral agent or designate and my parole/probation officer, bail supervisor or designate. I further acknowledge that a treatment summary will be sent to the above noted referral agent when I leave the program at Kinghaven Treatment Centre.

Client Signature: _____ Date: _____

BRITISH COLUMBIA | Ministry of Social Development and Social Innovation

CONFIRMATION OF INCOME

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*. The information will be used for eligibility purposes. The collection, use and disclosure of personal information are subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. Questions regarding the collection, use, and disclosure of personal information can be directed to an Employment and Assistance Worker by phone at 1-866-866-0800.

Service Provider Name	Fax Number
Kinghaven Treatment Centre	1-604-864-9420
Address	
31250 King Road, Abbotsford, BC V2T 6C2	

Clients receiving assistance from the Ministry of Social Development and Social Innovation must inform the Ministry of their request to enter residential care/treatment prior to funding. The Ministry will process applications for funding once notified of the client's arrival on the date of admittance by the facility faxing the HR3319 to the Ministry of Social Development and Social Innovation.

Client Full Name		
Phone Number	Date of Birth	SIN Number

I hereby authorize the staff from the Ministry of Social Development and Social Innovation to release information from my file required to establish eligibility for funding. This includes any income received or pending, and any missing documents that might affect my eligibility.

Client Signature _____ Date Signed _____

To be completed by ministry staff

Does the client have an open file? ○ Yes ○ No

Is the client receiving any other income? ○ Yes ○ No

Source of income _____

Amount of income _____

Is the client pending any other income? ○ Yes ○ No

Source of pending income _____

Notes

GA NUMBER: _____

Ministry Staff Signature _____ Date Signed _____

*Be advised information is accurate as declared to the Ministry as of the date signed.

HONOS ASSESSMENT (Health of the Nation Outcome Scales)

Name: _____

1. **Rate** each scale in order from 1 to 12
2. **Do not** include information rated in an earlier item except for item 10 which is an overall rating
3. **Rate** the MOST SEVERE problem that occurred during the 2 weeks prior to this rating.

1. Overactive, aggressive, disruptive or agitated behaviour - Include behaviour due to drugs, alcohol, dementia, psychosis, depression, etc. Do not include bizarre behaviour, rated at Scale 6

0 No problems of this kind during the period rated

1 Irritability, quarrels, restlessness etc. not requiring action

2 Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked agitation

3 Physically aggressive to others or animals; destruction of property, threatening manner;

4 At least one serious physical attack on others or on animals; destruction of property (e.g. fire-setting); serious intimidation or obscene behaviour

Comment: _____

2. Non-accidental self-injury

0 No problems of this kind during the period rated

1 Fleeting thoughts about ending it all but little risk; no self-harm

2 Mild risk during the period; includes non-hazardous self-harm, e.g. wrist-scratching

3 Moderate to serious risk of deliberate self-harm, including preparatory acts- collecting tablets

4 Serious suicidal attempt and/or serious deliberate self-injury

Comment: _____

3. Problem-drinking or drug-taking:

0 No problems of this kind during the period rated

1 Some over-indulgence but within social norm

2 Loss of control of drinking or drug-taking, but not seriously addicted

3 Marked craving or dependence on alcohol or drugs with frequent loss of control, risk taking under the influence, etc

4 Incapacitated by alcohol/drug problems

Comment: _____

4. Cognitive problems: Include problems of memory & understanding associated with any disorder; learning disability, dementia, schizophrenia, etc.

0 No problems of this kind during the period rated

1 Minor problems with memory or understanding, e.g. forgets names occasionally

2 Mild but definite problems e.g. has lost the way in a familiar place or failed to recognize a familiar person; sometimes mixed up about simple decisions

3 Marked disorientation in time, place or person, bewildered by everyday events; speech is sometimes incoherent; mental slowing

4 Severe disorientation e.g. unable to recognize familiar faces, speech incomprehensible

Comment: _____

5. Physical illness or disability problems: Include illness or disability from any cause.
Include side-effects from medication; effects of drug/alcohol use; physical disabilities

0	No physical health problem during the period rated
1	Minor health problem during the period (e.g. cold, non-serious fall, etc.)
2	Physical health problem imposes mild restriction on mobility and activity
3	Moderate degree of restriction on activity due to physical health problem
4	Severe or complete incapacity due to physical health problem

Comment: _____

6. Problems associated with hallucinations and delusions irrespective of diagnosis
Include odd and bizarre behaviour associated with hallucinations or delusions

0 No evidence of hallucinations or delusions during the period rated

1 Somewhat odd or eccentric beliefs not in keeping with cultural norms

2 Delusions of hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, i.e. clinically present but mild.

3 Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour, i.e. moderately severe clinical problem

4 Mental state and behaviour is seriously and adversely affected b delusions or hallucinations, with severe impact on patient

Comment: _____

7. Problems with depressed mood

0 No problems associated with depressed mood during the period rated

1 Gloomy; or minor changes in mood

2 Mild but definite depression and distress: e.g. feelings of guilt; loss of self-esteem

3 Depression with inappropriate self-blame, preoccupied with feelings of guilt

4 Severe or very severe depression, with guilt of self-accusation

Comment: _____

8. Other mental and behavioural problems: Specify the type of problem by circling the appropriate letter both here and on the score sheet: A phobic; B anxiety; C obsessive-compulsive; D stress; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify

0 No evidence of any of these problems during period rated

1 Minor non-clinical problems

2 A problem is clinically present at a mild level, e/g patient/client has a degree of control

3 Moderately severe level of problem; Occasional severe attack or distress, with loss of control

4 Severe problem dominates most activities

Comment: _____

9. Problems with relationships: Rate most severe problem associated with active or passive withdrawal from social relationships and/or non-supportive, destructive or self-damaging relationships

0 No significant problems during the period

1 Minor non-clinical problem

2 Definite problems in making or sustaining supportive relationships; evident to others

3 Persisting major problems due to active or passive withdrawal form social relationships, and/or relationships that provide little or no comfort or support

4 Severe and distressing social isolation and/or withdrawal from social relationships

Comment: _____

10. Problems with activities of daily living: e.g. eating, washing, dressing, toilet; complex skills - budgeting, finding housing, recreation, use of transport, shopping, etc. Include any lack of motivation for using self-help opportunities as this contributes to a lower overall level of functioning.

0 No problems during the period rated; good ability to function in all areas

1 Minor problems only: e.g. untidy, disorganized

2 Self-care adequate but major lack of performance of one or more complex skills (see above)

3 Major problems in one or more area of self-care (eating, washing, dressing, toilet) as well as major inability to perform several complex skills

4 Severe disability or incapacity in all or nearly all areas of self-care and complex skills

Comment: _____

11. Problems with living conditions and daily domestic routine: Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and opportunities to use intact skills and develop new ones?

0 Accommodation and living conditions are acceptable;

1 Accommodation is reasonably acceptable although there are minor problems

2 Significant problems with one or more aspects of the accommodation

3 Distressing multiple problems with accommodation; e.g. some basic necessities absent; housing environment has minimal or no facilities to improve patient's independence

4 Accommodation is unacceptable:

Comment: _____

12. Problems with occupation, activities in daytime environment. Is there help to cope with disabilities? Are there opportunities to maintain/improve skills and activities? Consider stigma, access to supportive facilities and qualified staff.

0 Patient's day-time environment is acceptable and supportive of self-help

1 Minor or temporary problems requiring little action e.g. late cheques; reasonable facilities available but not always at desired times, etc.

2 Limited choice of activities – lack of permanent address or insufficient career or professional support; helpful day setting available but for very limited hours

3 Marked deficiency in skilled services available to help minimize level of existing disability; no opportunities to use intact skills or add new ones;

4 Lack of opportunity for daytime activities makes patient's problems worse

Comment: _____

HoNOS Score Sheet			
	Rate 9 if not known		**Rate**
1	Overactive, aggressive, disruptive behaviour	**0 1 2 3 4**	
2	Non-accidental self-injury	**0 1 2 3 4**	
3	Problem-drinking or drug-taking	**0 1 2 3 4**	
4	Cognitive problems	**0 1 2 3 4**	
5	Physical illness or disability problems	**0 1 2 3 4**	
6	Problems with hallucinations and delusions	**0 1 2 3 4**	
7	Problems with depressed mood	**0 1 2 3 4**	
(Specify disorder A,B,C,D,E,F,G,H,I, or J)			
8	Other mental & behavioural problems	**0 1 2 3 4**	
9	Problems with relationships	**0 1 2 3 4**	
10	Problems with activities of daily living	**0 1 2 3 4**	
11	Problems with living conditions	**0 1 2 3 4**	
12	Problems with occupation and activities	**0 1 2 3 4**	

Edited by Gavin Andrews MD, UNSW, Jan 03 © 2003 CRUfAD

GAIN ASSESSMENT Date: _____

Name: a._____ b._____ Age: _____
(First name) (Last Name)

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for **two or more weeks**, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following statements, please tell us the last time you had this problem, if ever, by circling the appropriate corresponding number.

	Past month	2 to 12 months ago	1 + years ago	Never
	3	2	1	0
1. When was the last time you had significant problems...				
a. With feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	3	2	1	0
b. With sleeping, such as bad dreams, sleeping restlessly or falling asleep during the day?	3	2	1	0
c. With feeling very anxious, nervous, tense, fearful, scared, panicked or like something bad was going to happen?	3	2	1	0
d. When something reminded you of the past and you became very distressed and upset?	3	2	1	0
e. With thinking about ending your life or committing suicide?	3	2	1	0
2. When was the last time you did the following things two or more times?				
a. Lied or conned to get things you wanted or to avoid have to do something?	3	2	1	0
b. Had a hard time paying attention at school, work or home?	3	2	1	0
c. Had a hard time listening to instructions at school, work or home?	3	2	1	0
d. Were a bully or threatened other people?	3	2	1	
e. Started fights with other people?	3	2	1	0
3. When was the last time...				
a. You used alcohol or drugs weekly?	3	2	1	0
b. You spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high or sick)?	3	2	1	0
c. You kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	3	2	1	0
d. Your use of alcohol or drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events?	3	2	1	0
e. You had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems?	3	2	1	0
f. Had a disagreement in which you pushed, grabbed or shoved someone?	3	2	1	0
g. Took something from a store without paying for it?	3	2	1	0
h. Sold, distributed or helped to make illegal drugs?	3	2	1	0
i. Drove a vehicle while under the influence of alcohol or illegal drugs?	3	2	1	0
j. Purposely damaged or destroyed property that did not belong to you?	3	2	1	0

Do you have other significant psychological, behavioural or personal problems you want treatment for or help with? ☐ YES ☐ NO

If yes, please describe: _____

For Returning Clients:

Thanks so much for your interest in returning to Kinghaven. We recognize that coming to intensive residential treatment requires a big commitment on your part. We are asking you to complete and return this questionnaire to get a better idea if we can help you be successful in your desire to transform your life. Feel free to attach additional pages if needed.

1. We realize that something worked well the last time you were here, otherwise you wouldn't want to return. What do you feel that you and the Staff did really well the last time you were at Kinghaven?

2. Why did you leave treatment the last time? (Please be as honest and detailed as possible).

3. What do you intend to do differently this time at Kinghaven? How do you feel Staff can best assist you do that?

4. What medications do you take? Since you were last here how have your medications changed and how do you feel that is working for you?

5. What have you done to support your recovery since you left Kinghaven?

Thanks for completing this and we look forward to hearing from you.

KINGHAVEN
TREATMENT CENTRE

Things to Know

Please give this to clients:

We look forward to having you here at Kinghaven. To make your treatment experience as smooth as possible, this is a list of things to know before you arrive:

1. Admissions are by appointment only. Our intake days are Monday to Thursday mornings. We do not schedule intakes for Fridays, weekends or statutory holidays. Exceptions may be made for clients arriving from outside the Lower Mainland/Fraser Valley area.

2. Call us every day between 9:00-10:00am to check in. ***Failure to check in may result in removal from the waiting list.*** Call 604-864-0039, Ext 210. Our toll free line is 1-877-864-0039.

3. If you are on medications, please bring a new, written prescription for 2 weeks to ensure you have adequate supply to last until you see our house physician. ***Do not bring your own medications.***

4. If you are on methadone, bring a new, written prescription with the original hard copy for 2 weeks to ensure you have adequate supply until you see our house physician. ***If you arrive without a new methadone prescription you may be denied admission.*** We cannot assist you in obtaining a new prescription after your arrival until you see our house doctor.

5. ***Protein powders are not permitted***. If you need a specialized protein diet it will be developed by our dietician and kitchen staff to meet your needs.

6. Do not bring over-the-counter medications including vitamins. If these are needed they will be prescribed by our house doctor, purchased from our pharmacy at your expense and administered by staff along with other medications. No prescribed or over-the-counter medications are permitted to be kept in your room or on your person except by special permission.

7. Kinghaven does not pay for or extend credit for any medications. All medication costs must be paid in advance before we will order them from Shoppers. You are responsible for ensuring that the costs of your medications are covered by Pharmacare, Extended Health Insurance or self-pay. If there is any doubt, confirm your status by calling Pharmacare at 604-683-7151 or 1-800-663-7100. Note that Shoppers does not always bill direct to your insurer. In such cases you will need to pay in advance and then seek reimbursement from your insurer on your own.

8. ***If you bring a cell phone it will be locked up in safekeeping for the duration of your stay.*** You will not have access to it until you leave. If you have any important phone numbers stored on it, write them down ahead of time. You will have access to payphones during your stay. The payphones are set up for outbound and inbound calls.

9. If you are a client of the Ministry of Social Development on regular assistance or disability (PWD) you receive a comfort allowance of $95 per month while you are at Kinghaven (unless you owe them money in which case they may make a deduction from your allowance). You do not receive your full benefits

10. Hair cutting is not allowed onsite. If you bring hair cutting or beard trimming equipment with you it will be confiscated, placed in safekeeping and returned to you when you leave. Hair cutting and beard trimming should be done at home when you are on weekend passes.

11. ***Per Fraser Health licensing and for sanitary and pest control management, food is not allowed anywhere except in the cafeteria. Also, food including snacks and beverages cannot be brought onto the property from outside sources***. Food cannot be kept in rooms. If you bring food with you (or back with you from any off-site visits) you will need to consume it before we will assign you to a room or it will be confiscated and disposed of. We do not store food.

12. If you are arriving via Greyhound, call us at 604-864-0039, Ext 210 from the Abbotsford depot when you arrive. We do not meet buses so you need to call us to let us know you are there. We'll pick you up as soon as possible after your call.

12. Do not bring cell phones (even if they don't work), any wifi-capable devices (even if they don't work), DVD players, personal gaming devices, televisions, stereos, bedding, towels, valuables or breakables, over the counter medications including vitamins and protein powders, mouthwash, hair clippers or beard trimmers. Any of these items will be locked up in safe keeping for the duration of your stay and will not be accessible to you under any circumstances.

13. Do bring alcohol-free personal hygiene products (shampoo, soap, toothbrush, etc), comfortable and appropriate clothing and footwear including athletic wear, personal identification, a small alarm clock, a clear water container, telephone card to use the payphones, tobacco products for a minimum 3 weeks, and $10.00 linen deposit. You will need money for laundry. Detergent can be purchased from Kinghaven but you may wish to bring your own. In warmer weather, you may wish to bring a small desk-top fan.

14. Due to space restrictions, clients are permitted 1 suitcase and 1 small bag of possessions. Excess belongings will be sent home. All bags will be searched.

15. Vehicles, bicycles and other modes of personal transportation are not permitted while you are at Kinghaven. Please leave them behind.

BRITISH COLUMBIA Ministry of Health

MEDICAL PRACTICE
ACCESS TO PHARMANET AGREEMENT

PHARMANET

Patient Consent to Access PharmaNet

Kinghaven Treatment Centre

The province of British Columbia has established the provincial computerized pharmacy network and database known as "PharmaNet" pursuant to section 37 of the Pharmacists, Pharmacy Operations and Drug Scheduling Act, R.S.B.C 1996, c. 363, and which may be continued pursuant to section 13 of the Pharmacy Operations and Drugs Scheduling Act , S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I, _____, authorize

Dr. Johan Wouterloot

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named physicians.

Executed at_____this _____ day of_____, _____.

SIGNED AND DELIVERED by

_____

Patient(print)

in the presence of:

_____

Witness (signature)

_____

Witness (print)

_____

Date

X_____

Patient (signature)